Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box

Box Number 19

Respondent Name

NATIONWIDE MUTUAL FIRE INSURANCE

MFDR Date Received

AUGUST 9, 2004

MFDR Tracking Number

M4-04-B533-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this instance, the patient was admitted for three days for inpatient services on an emergency basis. Therefore, in accordance with the formula, the WCRA is 3 X $870.00 = $3,480.00. The prior amount paid by the carrier was $0. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of (3 X $870.00) = **$3,480.00, plus interest**."

Amount in Dispute: $14,750.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a fee dispute involving DOS 9/8/03 through 9/12/03. According to Rule 134.600(h), the services requested required preauthorization. Preauthorization was requested. However, this request was denied. Therefore, there is no entitlement to payment."

Response Submitted by: Nation Wide Insurance, FOL, 505 West 12th St., Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2003 through September 12, 2003	Inpatient Services	$14,750.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.

3. 28 Texas Administrative Code §134.600, effective January 1, 2003, 27 TexReg 12359, requires preauthorization for non-emergency inpatient hospitalizations.
4. 28 Texas Administrative Code §133.1, effective June 5, 2003, 28 TexReg 4293, defines a medical emergency.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- Z-Preauthorization requested but denied.

Findings

1. 28 Texas Administrative Code §134.600(b)(1)(A), applies in pertinent part that "b) The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: (1) listed in subsection (h) or (i) of this section, only when the following situations occur:
(A) an emergency, as defined in § 133.1 of this title (relating to Definitions)."

   The requestor disagrees contends that payment is due because this admission was for emergency services and preauthorization was not required.

2. 28 Texas Administrative Code §133.1(a)(7)(A), states "Emergency-Either a medical or mental health emergency as described below: (A) a medical emergency consists of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part."

   Based upon the submitted documentation, the requestor did not support position that the disputed services were for a medical emergency; therefore, preauthorization was required for the inpatient hospital admission per 28 Texas Administrative Code §134.600(h)(1).

   No documentation was found to support that the disputed services were preauthorized in accordance with 28 Texas Administrative Code §134.600(h)(1). As a result, payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

2/20/2013

Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.